CPHC

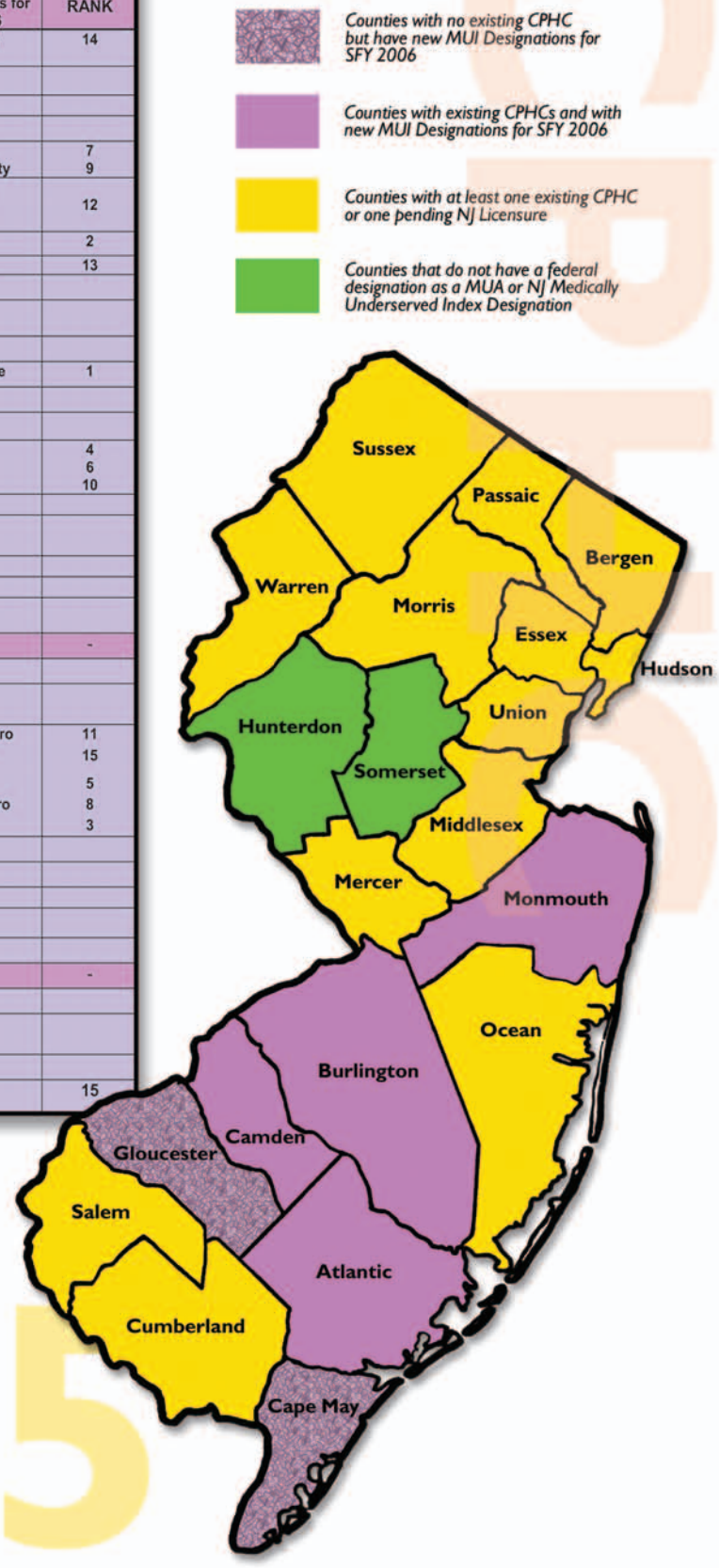
Expanding Primary Health Care in New Jersey through Centers for Primary Health Care

Caring for the Medically Underserved.

2005

New Jersey Centers for Primary Health Care
Existing, New and Proposed for 2006

County	CPHC by Municipality	NJ Licensed Operating Sites	Pending NJ Lic. by June, 2005	Proposed CPHC Sites Based on NJ Medically Underserved Index*	
				Proposed New Site Locations for SFY 2006	MUI RANK
Atlantic	Atlantic City	3	1	Absecon City	14
	Pleasantville	1			
	Hammonton	1	1		
Bergen	Garfield		1		
Burlington	New Lisbon/Pemberton		1	Mount Holly Burlington City	7 9
Camden	Camden City	5		Lindenwold Borough	12
Cape May (New County)				Wildwood	2
				Middle Twp.	13
Cumberland	Bridgeton	4			
	Vineland	1			
	Millville	1			
Essex	Newark	6		City of Orange	1
	East Orange	1			
	Irvington	1			
Gloucester (New County)				Paulsboro Woodbury Glassboro	4 6 10
Hudson	Jersey City	6			
	West New York	3			
	Union City	1			
	North Bergen	1			
	Hoboken	1			
Hunterdon	-	-	-	-	-
Mercer	Trenton	3			
Middlesex	New Brunswick Perth Amboy	1 1	1 5		
Monmouth	Asbury Park Keyport Long Branch	1 1 2		Highlands Boro Belmar Boro Freehold Red Bank Boro Keansburg	11 15 5 8 3
Morris	Dover	1			
Ocean	Lakewood	1			
Passaic	Passaic City	1			
	Paterson	2			
Salem	Salem City	1			
Somerset	-	-	-	-	-
Sussex	Newton		1		
Union	Plainfield Elizabeth	3 1			
Warren	Phillipsburg		1		
Total		55	12		15



*A Medically Underserved Index is a municipality designated as medically underserved by the Commissioner of Health and Senior Services based on the New Jersey Medically Underserved Index (NJMUI). The Index was developed to rank New Jersey's municipalities according to indicators that are potentially indicative of a lack of access to comprehensive and timely primary health care services. The indicators may change from year to year as more appropriate indicators are identified for use in the Index. The economic and health status indicators may include: (1) Percent of Population below 100 Percent of Poverty Level; (2) Percent of Population below 200 Percent of Poverty Level; (3) Percent of Population Unemployed; (4) Per capita Personal Income; (5) Teenage Fertility Rate per 1,000 Population; (6) Hospital Discharges for Preventable Diabetes Conditions per 100,000 Population; (7) Age Adjusted Death Rates per 100,000 Population; and, (8) Years of Potential Life Lost per 100,000 Population.

April, 2005

Letter from the Commissioner

Fred M. Jacobs, M.D., J.D.
Commissioner
New Jersey Department of Health
and Senior Services

Dear Colleagues:

For forty years, community health centers have provided needed primary and preventive medical and dental care to millions of citizens who would have otherwise not received appropriate health care.

Today, New Jersey is among only a few States in this country that has recognized the true value of the federal support to community-based agencies in our state by supplementing this support with state funding to expand the safety net for our citizens.

In his January 2005 State of the State Message, Acting Governor Richard Codey acknowledged the extraordinary services provided by New Jersey's Centers for Primary Health Care (CPHC), many of which are federally funded, others that are only funded by the State of New Jersey. The Acting Governor is seeking budgetary support from the NJ Legislature to continue to identify new primary care access points with the hope of opening 10 additional sites and funding to support major facility expansions for those existing sites that need more space to accommodate an increasing number of patients and expanding services.

Additionally, Acting Governor Codey is encouraging every eligible CPHC in New Jersey to participate in the 340-B Pharmacy Discount Program administered by the U.S. Department of Health and Human Services/Health Resource and Services Administration (HRSA). Under this initiative, the state will provide support to CPHCs to help develop formularies, business plans, fee schedules, and tracking systems to help the centers get a "jump start" on program implementation. Access to needed medications is important to all patients, and critical to patients with chronic diseases.

The number of uninsured residents in New Jersey is growing. Currently, over 1.3 million of our citizens do not have health care insurance coverage. An untold number of other citizens, including seasonal farm workers who work on our blueberry and cranberry farms, are also without needed insurance coverage for their families. However, federal support for migrant and seasonal farm workers in our state has assisted us in providing this population with access to needed medical care.

I congratulate the thousands of clinicians, professionals and support staffs who have dedicated their lives to the community health care movement of 40 years. The continued support of community based primary health care programs with both federal and state funding is testament to the dream envisioned by President Lyndon B. Johnson in designing his "Great Society" programs.

Sincerely,

Fred M. Jacobs, M.D.
Commissioner

Prepared By

Carolyn G. Holmes

Senior Advisor to the Commissioner

New Jersey Department of Health and Senior Services

March 2005

(Revised April 2005)

Centers for Primary Health Care • Caring for the Medically Underserved

Preface

Over 1.3 million New Jerseyans do not have health insurance coverage. This number does not include the recently unemployed who have been without health insurance for less than 12 months nor undocumented residents, including migrant and seasonal farm workers.

The State of New Jersey has long recognized the need to provide comprehensive primary health care services for the medically underserved. Since 1991, NJ state funding has supplemented federal grants to community based organizations providing health care services to the state's most vulnerable populations, whether they lived in cities, suburbs or in campsites on the state's cranberry and blueberry farms.

As the number of individuals and families experience difficulty accessing needed health care, health conditions that could have been addressed in a primary setting may now need to be addressed in a hospital. Access can mean different things to different people – insurance coverage, geography, cultural competencies of clinicians, knowledge of public health issues, etc. Whatever the definition or terminology, disparities to health care in the nation and in New Jersey must be addressed in order to improve health outcomes.

In addition to financial support from New Jersey's Health Care Subsidy Fund since 1991, special state appropriations were made available each year in 2004 and 2005 ($10 million each year) to increase the capacity of existing federally qualified health centers and to establish 10 new primary health care access points in medically underserved areas. Because health centers are now both federally qualified and/or funded and state funded, they are referred to as NJ Centers for Primary Health Care (CPHC).

This report provides a history of primary and preventive community health care from both the federal and state perspectives, summarizes strategies to increase access to care, and provides a progress report on facility and program expansions.

Though more lengthy that the 2004 report, this summary will enlighten policy makers as to the depth of the services provided by CPHCs and the challenges they face to meet the needs of over 250,000 patients.

April 2005

New Jersey Centers for Primary Health Care
Caring for the Medically Underserved
2005

OUTLINE

DATA TABLES

I. History of Community Health Center Programs

President Lyndon B. Johnson's "Great Society" Programs

Created as part of President Lyndon B. Johnson's "Great Society Programs", community health centers have provided access to primary care for underserved populations for 40 years. In President Johnson's first State of the Union Message, he called for a war on poverty that included a major expansion in the federal government's role in domestic policy. The elimination of poverty was in the forefront of federal domestic issues during the years 1964 -1974. Many of the "Great Society" programs created during the mid-sixties are still operational, including the community health center program, Medicare and Medicaid, Head Start, Volunteers in Service of America, Job Corps and others. ***(Photo: President Johnson signing the Economic Opportunity Act (Great Society War on Poverty), August 25, 1964)***

There were many lessons learned during the first decade of the community health center movement. In addition to providing needed medical care, the centers were required to provide enabling services such as community outreach, transportation, and multilingual services to facilitate access to the medical services that were offered. In return, community health centers received federal funds for start-up costs and received operating subsidies that allowed them to function in environments where most patients had limited means to pay for care.

In 1975, Congress enacted legislation that gave more permanent status to Neighborhood Health Centers, which became known as Community Health Centers (CHC). From the mid 1970s to the late 1980s, community health centers experienced an unstable stream of rising and falling financial support from the federal government. Many of them failed, while others thrived and were able to meet the many needs of their communities.

In 1989, Congress passed Section 4161 of the Omnibus Budget Reconciliation Act (OBRA), which created the special designation of Federally Qualified Health Centers (FQHC), thus the use of the acronym FQHC, often used to describe community health centers. OBRA made federally qualified health center services required services under Medicaid. ***OBRA required FQHCs to comply with the following guidelines in order to be designated as a FQHC:***

- **Serve a federally designated health professional shortage area, medically underserved area, or medically underserved population as determined by the federal Bureau of Primary Health Care**
- **Provide services to patients regardless of insurance status**
- **Use a sliding fee scale for uninsured patients based on their income**
- **Operate as a nonprofit corporation governed by a board of directors of which a majority are users of the health center**

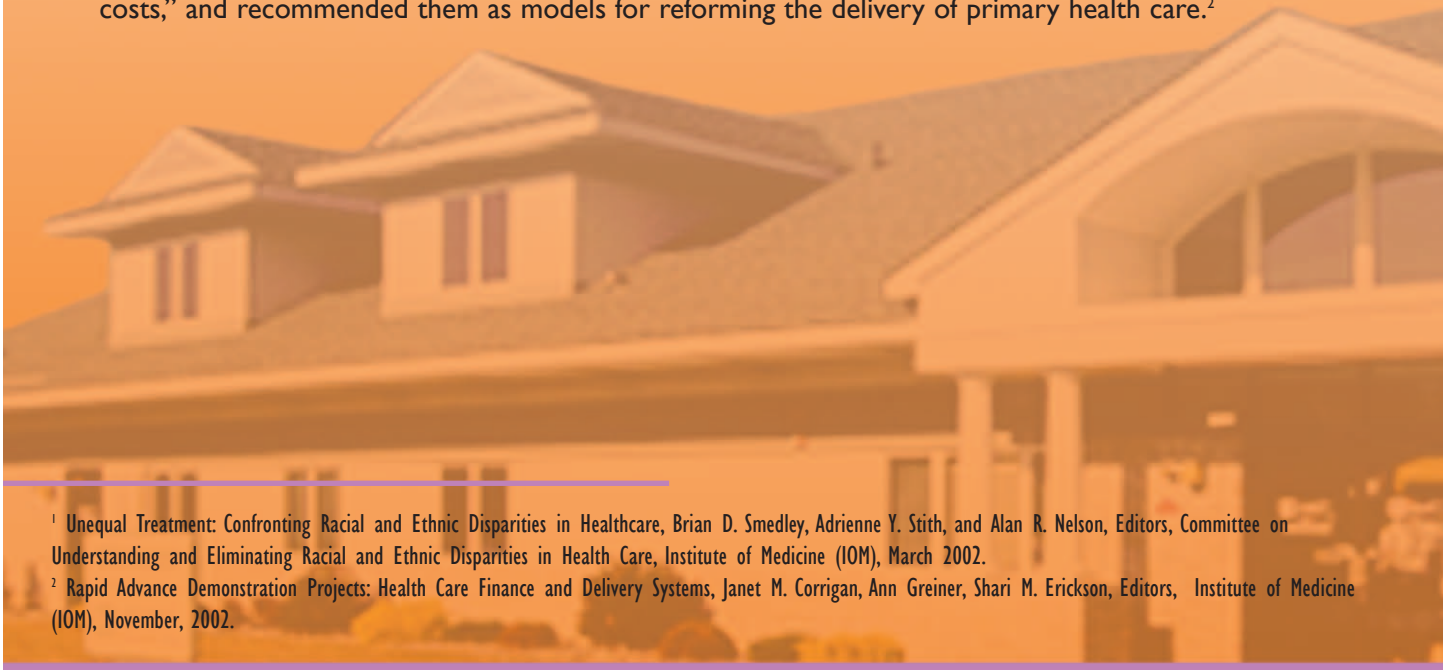
In practice, the federally qualified health centers include all organizations receiving grants under section 330 of the Public Health Service Act, specifically, Community and Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Programs, and School Based Health Centers. Certain Tribal Health Programs are also eligible for FQHC status. Finally, federally qualified health centers that do not receive Section 330 grants may receive FQHC Look-ALike status if they meet a majority of the requirements described above.

The medically underserved populations served by federally qualified health centers include people who are poor or near poor, Medicaid recipients, the uninsured and racially and ethnically diverse low-income adults, children and senior citizens. Other categorical groups served by the centers include homeless individuals and families, migrant and seasonal farm workers people living in isolated rural and frontier areas, residents of the U. S./Mexico border, Native Hawaiians and Pacific Islanders, persons living with Hansen's disease (Leprosy) and persons living with Black Lung disease.

Today, federally qualified health centers serve over 14 million individuals and families annually in 50 states and U.S. territories. Over 1,000 community-based organizations operate 3,740 health center sites in urban and rural areas and on Indian reservations. In 2003, federally qualified health centers generated more than 49 million patient visits.

Over the 40-year history of federally qualified health centers, a number of studies have been conducted to evaluate the success of FQHCs in reducing and eliminating economic, racial and ethnic health disparities. In 2002, in a study conducted by the Institute of Medicine (IOM), ***Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare***, the authors specifically noted that the FQHC model "has proved effective not only in increasing access to care, but also in improving health outcomes for the often higher-risk populations they serve."[1]

A November 2002 study by IOM, "Rapid Advances in Health Care: Learning from System Demonstrations," praised health centers for their "strong record . . . [of] providing care that is at least as good as, and in many cases superior to, the overall health system in terms of better quality and lower costs," and recommended them as models for reforming the delivery of primary health care.[2]



[1] Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine (IOM), March 2002.

[2] Rapid Advance Demonstration Projects: Health Care Finance and Delivery Systems, Janet M. Corrigan, Ann Greiner, Shari M. Erickson, Editors, Institute of Medicine (IOM), November, 2002.

Acting Governor Richard J. Codey and Senator Wayne R. Bryant continue to support primary health care in New Jersey.

II. New Jersey Support for Community Health Care

Since 1969, federally qualified health centers have provided comprehensive primary health care to millions of medically underserved residents of the State of New Jersey. Many of these individuals and families would have gone without needed medical care or would have sought primary care in hospital emergency departments.

The growing need for primary health care for the medically underserved populations in the State became a priority for New Jersey lawmakers in the early 1990s. In 1991, Senator Richard Codey and Assemblyman Wayne Bryant co-sponsored Chapter 187, Senate Bill 3251 creating the **Health Care Cost Reduction Act** -- a comprehensive piece of legislation that addressed a number of major health and hospital related issues. The Act focused on the need for low-income residents of the state to have equal access to quality primary health care and hospital services, regardless of their ability to pay.

The New Jersey 1991 Health Care Cost Reduction Act addressed some of the following primary health care Issues:

- **Established the New Jersey Health Care Trust Fund, a non-lapsing fund created by an annual assessment of state-based hospitals;**
- **Established funding for community health centers to expand services as an alternative to using hospital emergency departments;**
- **Established the NJ Primary Care Physician and Dentist Loan Redemption Program;**
- **Defined "Medically Underserved Areas" as target areas for clinicians to seek job opportunities. In return, eligible clinicians received assistance to help cover medical and dental school loans;**
- **Established Pilot Programs that encouraged hospitals to refer indigent patients to federally funded community health centers for ongoing primary health care services;**
- **Established "HealthStart Plus" programs for pregnant women and infants;**
- **Established a "Competitive Initiatives Fund" to strengthen relationships between hospitals and community health centers;**

The original health subsidy fund allocation of $8 million to New Jersey's FQHCs included grants, special initiatives, and reimbursements to the centers for uninsured patient visits. Since the implementation of state support to FQHCs in 1991, the annual funding for uninsured health services has increased to $11 million in state fiscal year 2004. This level of funding was supplemented by a special state appropriation of $10 million for the 2004 and 2005 fiscal years to help cover increased numbers of uninsured patient visits, to develop new primary care sites in four counties with designated medically underserved areas, and to expand the capacity of existing licensed primary care facilities.

With rising numbers of uninsured families, predictions of $60 billion proposed federal Medicaid reductions over the next 10 years, and dismal projections of state budget deficits, the medically underserved are still at risk.

III. Federal Support for Community Health Care Programs

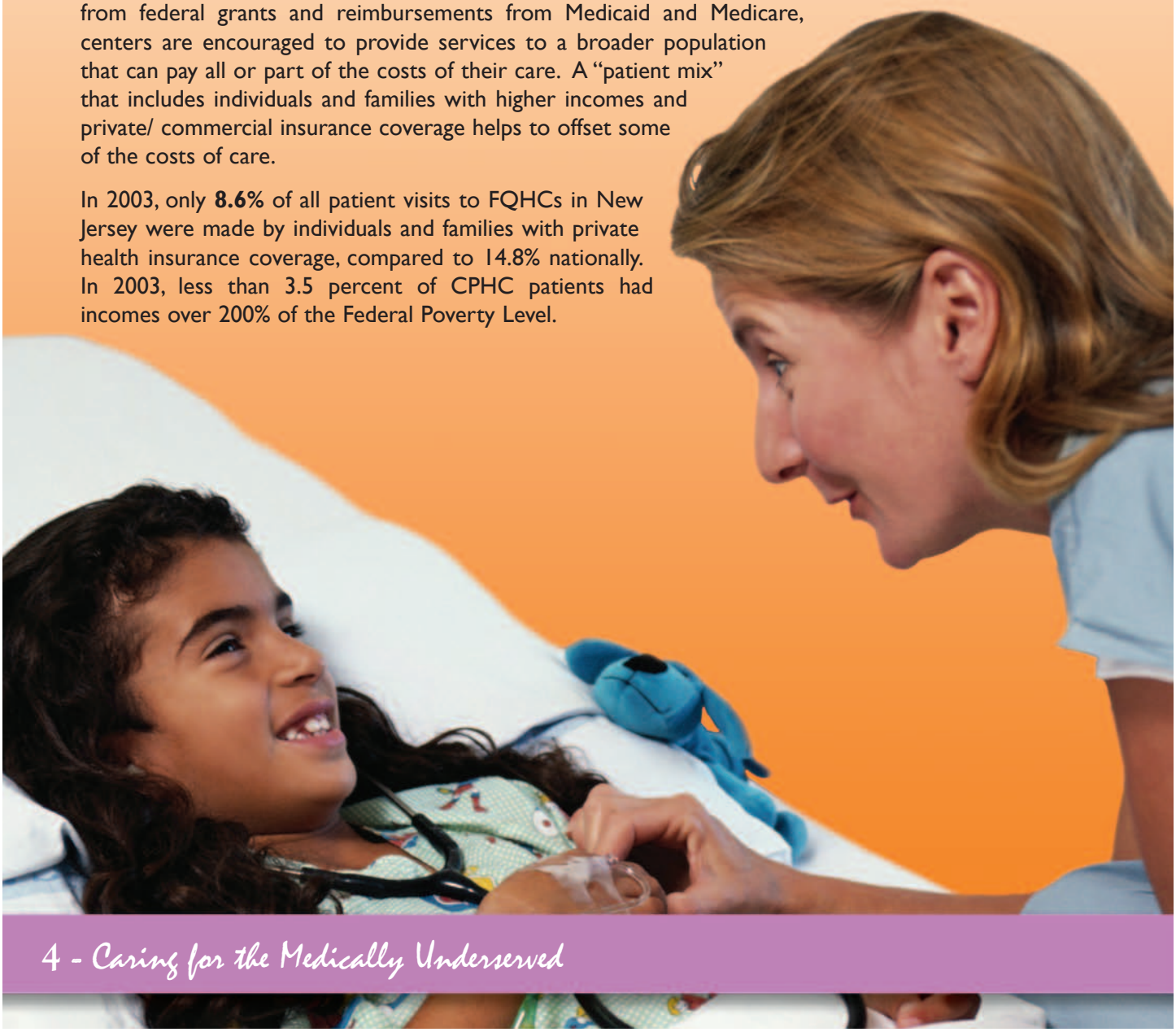
Over the years, FQHCs have demonstrated their ability to meet the needs of their patients by properly targeting their resources, discounting charges based on family income and sliding fee scales, and, as required by federal statutes, serving all patients seeking care, regardless of their ability to pay.

In the late 1990's, a growing number of health centers experienced serious financial difficulty due to several adverse factors. These included growth in the uninsured population, tightening reimbursement under Medicaid managed care, the phase-out of federally mandated cost-based reimbursement and the failure of federal health center grants to keep pace with the centers' rising costs.

Unfortunately, federal funding is not adjusted annually to meet increases in uninsured patient costs, operating expenses, provider salaries, negotiating bargaining unit increases, etc. Primary health care centers must make regular adjustments in operating expenses, seek financial support from private and public sources, and often borrow funds to make ends meet. Maximizing revenues becomes a juggling act when unexpected expenses exceed projections or revenue shortfalls occur.

While the majority of financial support for services provided by centers comes from federal grants and reimbursements from Medicaid and Medicare, centers are encouraged to provide services to a broader population that can pay all or part of the costs of their care. A "patient mix" that includes individuals and families with higher incomes and private/ commercial insurance coverage helps to offset some of the costs of care.

In 2003, only **8.6%** of all patient visits to FQHCs in New Jersey were made by individuals and families with private health insurance coverage, compared to 14.8% nationally. In 2003, less than 3.5 percent of CPHC patients had incomes over 200% of the Federal Poverty Level.

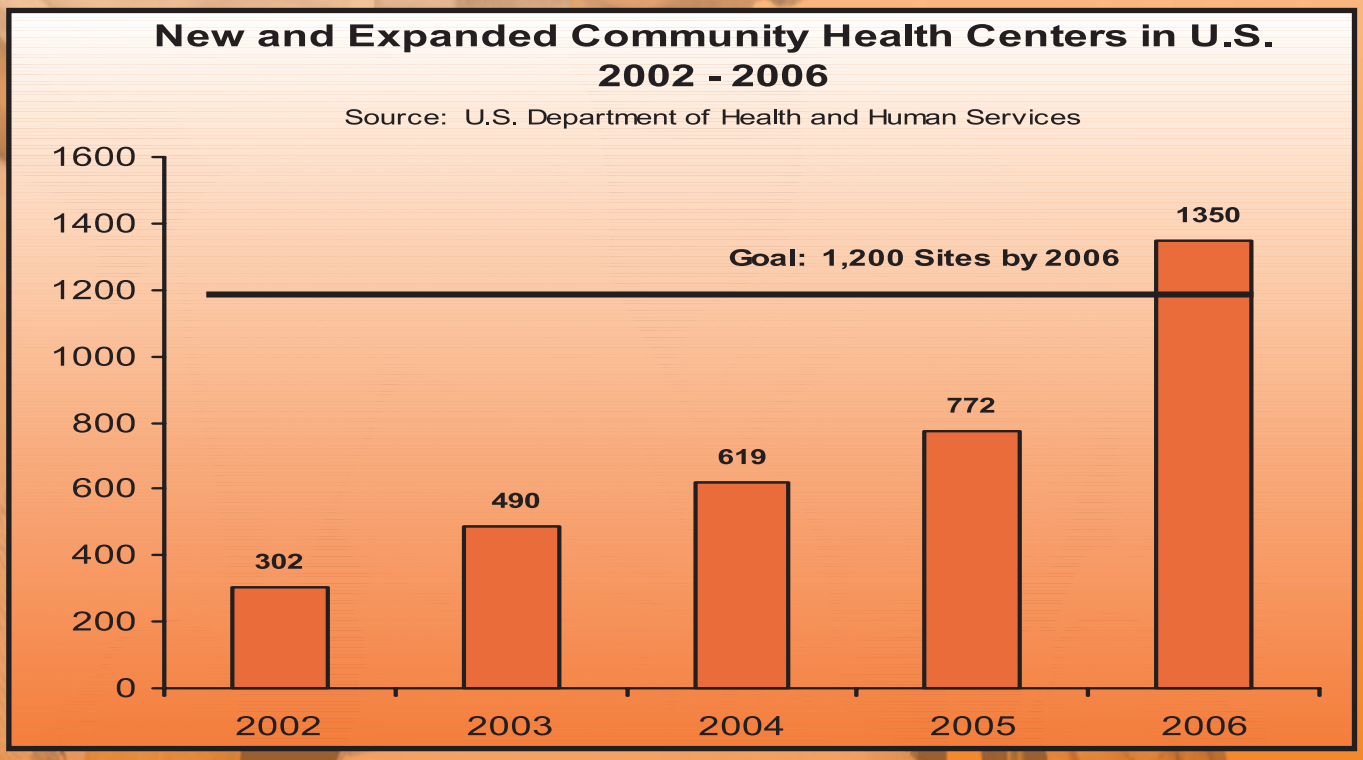


Public Health Service Act

Federal funding to support community based health care is provided by the Public Health Service Act administered by the U.S. Department of Health and Human Services/Health Resources and Services Administration (HRSA). For 40 years, community health programs have provided services to populations that lack access to appropriate primary and preventive care and who suffer from numerous disparities in the delivery of services as a result of ethnic, economic and language barriers.

The federal appropriation for FQHCs was $1.5 billion in 2004, and is estimated to exceed $1.6 billion in 2005. Approximately $2 billion is proposed for the Community Health Centers Program in FY 2006, an increase of $304 million. This figure includes $26 million to establish 40 new sites in "high poverty" counties. The increased federal support targeted to FQHCs in 2006 completes the Bush Administration's push to create 1,200 new health center sites to serve an additional 6.1 million patients by the end of 2006. Altogether, over 3,700 primary health care sites are currently federally funded and provide services to more than 14 million individuals and families.

The federal initiatives to increase access to primary health care will exceed original goals by the end of the 2006 federal fiscal year. The accompanying graph illustrates the growth of new and expanded FQHCs since 2002.



Over the years, various categorical programs have been created and funded by the federal government. These programs are designed to address the needs of many vulnerable groups. These programs include:

- **Community Health Center Programs for the Medically Underserved**
- **Health Care for the Homeless**
- **Migrant and Seasonal Farm Workers**
- **School-Based Health Services**
- **Health Services for Residents of Public Housing**
- **Healthy Communities Programs**
- **Programs for Special Populations**
- **National Hansen's Disease Program**
- **Radiation and Exposure Screening and Education Program**
- **Black Lung Clinics**

In addition to the above programs, federal health center expansion initiatives have made grants to:

- **Expand the capacity of existing centers**
- **Develop new access points**
- **Implement oral health programs**
- **Develop mental health and substance abuse services**
- **Initiate pharmaceutical services**
- **Develop and expand health disparities collaboratives to fight chronic diseases, including, asthma, cancer, diabetes, perinatal related conditions cardiovascular disease, and issues related to patient safety.**

By 2006, health centers will serve an estimated 16 percent of the nation's population at or below 200 percent of the Federal Poverty Line.

Revenues by Source

As indicated in **Table 1** below, of the total revenues generated by NJ Centers for Primary Health Care (CPHC) in 2004, federal grants represent 22% of total revenues, exceeded only by reimbursements from Medicaid.

Table 1
NJ Centers for Primary Health Care
Revenues by Source
January – December 2004

Federal/HRSA	**$23,808,923** (22.4%)
Medicare	**2,501,574** (2.30%)
Medicaid	**41,642,025** (39.1%)
NJ State Health Subsidy	**22,000,000** (20.7%)
Other Third Party Funds	**2,537,666** (2.40%)
Other Support	**14,085,403** (13.2%)
Total	**$106,474,591**(100%)

Source: NJ Primary Care Association, Quick Facts, February, 2005.

As indicated above, Medicaid reimbursement to CPHCs represents over 39% of total revenues. Any reductions in the Medicaid program would either reduce services offered or reduce the number of individuals and families covered by Medicaid.

The 2006 federal budget proposes to cut the Medicaid allocation by billions of dollars over the next five to ten years. In early March 2005, the Energy and Commerce Committee in the House of Representatives is directed to find $20 billion in savings over the next five years. The Senate instructed the Senate Finance Committee to find $14 billion in savings over the same time period, all from Medicaid.

Medicaid covers a full range of health services for the low income, disabled and the elderly through its managed care and fee-for-service programs. Medicaid also covers the costs of one-third of all births in the country and provides health insurance for one in every four children. Medicaid accounts for almost one-half of total spending on long-term care and much of state spending on programs for the mentally ill, mentally retarded and developmentally disabled.

To control these costs, the 2006 federal budget proposes to provide states with additional flexibility in spending Medicaid dollars in order to further increase optional coverage among low-income individuals and families without creating additional costs for the federal government.

IV. New Jersey Centers for Primary Health Care (CPHC)[3]

(State or Federally Funded and Federal Look-Alikes)

New Jersey Centers for Primary Health Care (CPHC) have provided services to residents, seasonal farm workers and the homeless since 1969, when Newark Community Union (Newark NJ/Essex) opened as New Jersey's first licensed, federally funded neighborhood health center. Other community-based organizations soon received federal support for primary health care services in New Jersey, including Plainfield Neighborhood Health Center, Inc.,1969 (Union County), Henry J. Austin Health Center, Inc., 1976 (Mercer County); Paterson Community Health Care Center, Inc., 1976 (Passaic County); and, Southern Jersey Family Medical Centers, Inc., 1977 (Salem and Atlantic Counties).

As of February, 2005, 20 community-based, private non-profit, IRS 501 (c) (3) organizations provide services in 67 licensed locations in 13 New Jersey counties. Northwest New Jersey Community Action Program, Inc. (Norwescap), a corporation established under President Johnson's Economic Opportunity Act Programs, is presently seeking New Jersey licensure to provide primary health care services in two medically underserved communities in Sussex and Warren Counties. Southern Jersey Family Medical Centers, Inc. will soon open a new facility in Burlington County; and, North Hudson Community Action Corporation will open a new site in Bergen County.

By June 2005, 17 New Jersey Counties will have at least one state or federally funded CPHC. Fifteen (15) New Jersey municipalities have been designated as meeting the ***Medically Underserved Index*** (MUI) criteria by the NJ Commissioner of Health and Senior Services. The MUI could be used to determine areas for future primary care sites.

[3] Health centers funded under the Public Health Service Act have interchangeably been referred to as neighborhood health centers, community health centers, federally qualified health centers (FQHCs), migrant health centers, and FQHC Look-Alikes. Special NJ State appropriations in fiscal years 2003 created 10 new community based health service programs. Since some of these programs have not achieved federal designation or funding, this report will refer to all such centers (those funded and/or designated by the U.S. Department of Health and Human Services and those funded by the State of New Jersey) as New Jersey Centers for Primary Health Care.

The Index was developed to rank New Jersey's municipalities with populations of 5,000 or more according to indicators that are potentially indicative of a lack of access to comprehensive and timely primary health care services. Municipalities are evaluated according to certain economic and health status indicators including, but not limited to:

- **Percent of Population below 100 Percent of Poverty Level;**
- **Percent of Population below 200 Percent of Poverty Level;**
- **Percent of Population Unemployed;**
- **Per capita Personal Income;**
- **Teenage Fertility Rate per 1,000 population;**
- **Hospital Discharges for Preventable Diabetes Conditions per 100,000 population;**
- **Age Adjusted Death Rates per 100,000 population; and,**
- **Years of Potential Life Lost per 100,000 population.**

The inside front cover provides a list of licensed CPHCs and the tables in the back of the booklet provide lists of CPHC organizations and sites by county, municipality.

2004 State Support for "Safety Net" Centers for Primary Heath Care

The number of uninsured New Jersey residents under 65 years of age steadily increased from 9.0 percent in 1987 to 15.8 percent in 2003. As the number of uninsured families continued to rise, CPHCs' capacity to meet rising demand needed to increase along with added financial support.

With support of the State of New Jersey, the 2004 State Budget included a special appropriation of $10 million dedicated to New Jersey's CPHCs. The funds were earmarked to expand existing CPHCs and to develop new access points in areas identified by the federal government as "Medically Underserved Areas" (MUAs) or areas with "Medically Underserved Populations".

FTCA

Medical Malpractice Insurance Program - Federal Torts Claims Act

The Federally Supported Health Centers Assistance Act (FSHCAA) of 1992 and the 1995 reauthorization, commonly referred to as the Federal Tort Claims Act or FTCA program, created a medical malpractice insurance program for CPHCS that offers full coverage for health center activities at no cost to grantees who participate. This program is designed to reduce or eliminate the need for "deemed" CPHCs to purchase private medical malpractice insurance thereby allowing more funds to be available for direct service to underserved populations.

In order to participate in the program a Health Center has to be "deemed" to be a federal employer. The law allows only organizations funded under sections 330 (e), (g), (h), and (i) to be eligible for coverage. They are more commonly known as Community Health Center, Migrant Health Center, Health Care for the Homeless, and Health Care for Residents of Public Housing grantees.

The deeming process, while not onerous, does have some basic requirements. Health Centers that wish to participate must assure the Bureau of Primary Health Care that they conduct complete and thorough credentialing of their providers including querying of the National Practitioner Data Bank. Clinical protocols, tracking systems, medical record review, and active quality assurance programs are required. Once "deemed", continued deeming is maintained through the Project Period Renewal Grant Application.

The Health Center FTCA program receives no direct appropriation from Congress. Funds to pay for settlements and judgments come from a pool created with money taken each year from the Health Center appropriation.[4]

[4] U.S. Department of Health and Human Services, HRSA, Federal Tort and Claim Act, Program Information.

Expand Capacity of Existing Centers

Under the NJDHSS' 2004 capacity building initiative, fourteen (14) existing FQHCs received a total of $4.5 million to increase and expand services. ***Funds were utilized to:***

- **Open new dental sites;**
- **Increase clinical and support staff;**
- **Renovate additional space for patient care; and,**
- **Increase operational hours.**

New Access Points for Primary Health Care

Studies to identify medically underserved areas and populations in New Jersey indicated that there were at least 10 target areas that were officially designated by the U. S. Department of Health and Human Services/HRSA as medically underserved. This designation is critical in that programs developed in these areas would be eligible to compete nationally for federal financial support. A total of $4.3 million was awarded to ten organizations to develop new primary care access points.

The strategy developed and implemented by the NJ Department of Health and Senior Services (DHSS) included:

- **Using state funding to develop new primary care access points in federally designated areas and to require agencies funded for these programs to seek federal designations as a "FQHC Look-Alike" and to apply for federal funding at the earliest date possible.**
- **Any agency funded by the state under this program that was not already a federally funded community health center must "partner" with an existing FQHC. The purpose of this requirement was to provide support and guidance for a new organization as it completed complicated state and federal regulatory processes and developed clinical and operational policies and procedures.**
- **This requirement forged partnerships between agencies within counties and across county lines that previously had not existed. For instance, Ocean Health Initiatives (Ocean County) partnered with Southern Jersey Family Medical Centers, Inc. (Atlantic County) for support. Dover Health Clinic (Morris County) partnered with Jersey City Family Health Center, Inc. (Hudson County).**
- **The Burlington County Department of Health executed an agreement with Southern Jersey Family Medical Center to develop community-based primary care services at a County owned facility in New Lisbon, NJ Burlington County).**
- **DHHS used every means to "leverage" limited state support to achieve permanent federal support for new access points or expanded capacity initiatives. The awarding of new federal grants is a testament to the merit of this strategy.**

Community-based agencies granted funds by the NJ DHSS under the special $10 million initiative are still in position to compete for federal funding if not yet funded, or to seek Look-Alike federal designations to enhance revenues. **Table 2** provides a status report of new state funded access points, including those that have successfully competed for federal funding.

Table 2 New Jersey Funded New Access Points for Primary Health Care			
Center for Primary Health Care	**County**	**Federal Designation or Funding**	**Status***
Long Branch Monmouth Family Medical	Monmouth	Federal Look-Alike Designation, September, 2004	Operational
Dover Dover Community Health Center	Morris	Federal Look-Alike Designation, July, 2004; **Federal Funded, October, 2004**	Operational
Irvington Operated by: Newark Community Health Center	Essex	**Federal Funded, October, 2004.**	Operational
Lakewood Ocean Health Initiative	Ocean	Federal Look-Alike Designation, March 2004	Operational
Passaic City Operated by: North Hudson Community Action Corp.	Passaic	**Federal Funded, October, 2004.**	Operational
Garfield Operated by: North Hudson Community Action Corporation	Bergen	Facility renovations/construction to be completed by June, 2005	Pending
Hoboken Operated by: North Hudson Community Action Corporation	Hudson	Facility renovations/construction to be completed by June, 2005 **Federally Funded, October, 2004**	Pending
Pemberton Operated by: Southern Jersey Family Medical Centers	Burlington	Facility renovations/construction near completion. **Federal Funding, October, 2004**	Pending
Newton Operated by: North West NJ Community Action Program	Sussex	Note: Initial grantee withdrew from process. Norwescap was funded in Summer of 2004; Negotiations with previous facility occupants were not settled until August 31, 2004. Anticipated date of services, April, 2005. An additional $40,000 private grant was secured to support operations at Newton.	Pending
Phillipsburg Operated by: North West NJ Community Action Program	Warren	Initial grantee withdrew from process. Norwescap was funded in Summer of 2004. A facility has been identified and renovations are underway. Anticipated date of services, June, 3005	Pending

* As of December, 2004

NJ CPHC Uninsured Patient Visits

Uninsured Patient Visits 2002 – 2005

In SFY 2002, ten community based health centers participating in the DHSS health subsidy program were reimbursed for 122,117 uninsured visits. In state fiscal years 2003 and 2004, the number of center sites and patients increased, and the number of uninsured reimbursed visits grew to 143,708 and 197,694, respectively. The annual grow rate for eligible uninsured patient visit reimbursements to CPHCs increased by 17.2 percent in state fiscal year 2003 and by 25.9 percent in 2004.

Projected Uninsured Visits and Costs

A total of $21 million was allocated in SFY 2005 (July 1, 2004 – June 30, 2005) to support the delivery of primary health care to eligible uninsured patients registered and receiving care at NJ Centers for Primary Health Care (CPHC). A 26.9 percent uninsured patient growth rate is projected for state fiscal 2005, with 250,859 uninsured patient visits to be covered by the state subsidy. The funding is derived from a $10 million state appropriation from the general fund and $11 million from the Health Care Subsidy Fund. The spending plan for the funding included:

Estimated reimbursement for eligible uninsured visits	$19,800,000
Supplemental support to 5 HealthCare for the Homeless Project in Atlantic City, Camden, Trenton, Newark and Jersey City	500,000
Two mental health projects supporting prisoner reentry case management	200,000
Operations and administration (Electronic data collection, evaluation, MIS, personnel, misc.)	500,000
Total	**$21,000,000**

In Acting Governor Richard Codey's 2005 State of the State Message, he proposed that state funding be allocated in state fiscal year 2006 to support ten (10) new Centers for Primary Health Care. Estimates are that these new centers in medically underserved areas of the state will provide services to a minimum of 30,000 additional residents and generate over 80,000 patient visits.

Based on the growth rate of uninsured visits to CPHCs, the start-up and establishment of primary care practices for expanded services and new access points, along with new services such as dental and mammography imaging and a revised formula for uninsured patient visits, the costs of supporting the uninsured initiatives are projected to increase as follows:

Table 3
Estimated Number of Uninsured Visits, Growth Rate and Costs
SFY 2006 and 2007

State Fiscal Year	Uninsured Visits	Visit Growth Rate	Cost*
2006	320,982	28.0%	$30.50 Million
2007	361,504	12.6%	34.34 Million

*Additional costs for the SFY 2006 will include: (1) uninsured visits to be generated by 10 new centers to be developed in SFY 2006; (2) mammography services that will be provided by 5 CPHC that recently received a donation of mammography imaging equipment by United HealthCare; (3) uninsured CPHC dental hygienists visits as a result in the change in scope of current Letters of Agreement; (4) supplemental grants to Health Care for the Homeless Programs; (5) electronic data collection, MIS and personnel; (6) colposcopy diagnostics; (7) $2 million for Primary Physician/Dental Loan Redemption Program; and, (8) asthma and diabetes collaboratives.

It is anticipated that costs for uninsured patient visits, services and support will total $35 million to $37 million for SFY 2006 and higher for 2007.

Electronic Data Collection Uninsured CPHC Visits

Since the inception of New Jersey's financial support for uninsured patient visits in 1991, all patient related information and billing processes have been transmitted manually to the Division of Family Health Services, NJ DHSS. Over the years, all federally supported CPHCs have achieved some level of electronic data management; however, the transmittal of data from multiple agencies from different computer operating systems and different patient management software programs was impossible to translate into a universal computer language for data management purposes.

In SFY 2004, a grant was provided to the New Jersey Primary Care Association and its data warehouse subsidiary, KeyCare, LLC to develop an electronic data collection system that could convert patient data into a universal format. By September, 2004, the system design for electronic data collection was near completion and data from 10 CPHC were uploaded for testing and transmittal. During the last quarter of calendar year 2004, the data collection system was refined and adjusted to address differences in agency programs and services, conversions and reconciliation of data, etc.

Today, the Uncompensated Care MIS Data Collection System is functional and is able to summarize local patient data and transmit such data to the State. The system must be modified this fiscal year and in 2006 as new CPHC sites become operational. By June 30, 2005, it is anticipated that data from all 20 existing CPHC agencies will be integrated in the new electronic data system.

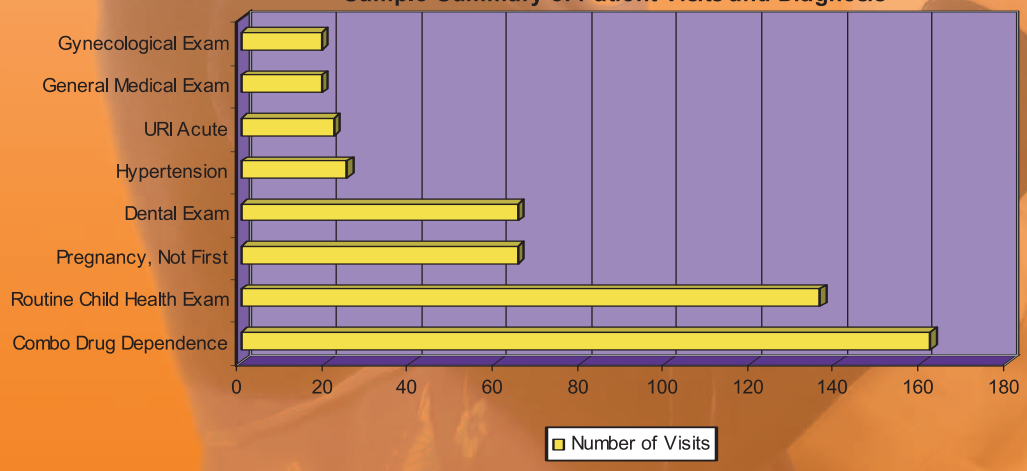
The new electronic system consists of the following:

- **Number of total patients and patient visits by individual CPHC site**
- **Patients and Patient Visits by Race, Sex, Age Group, and Income Level**
- **Patient diagnosis by sex and age; ranking diagnoses by age and sex**
- **Patient diagnosis by payer source (Uninsured, Medicaid, Medicare, Other)**
- **Patient visits by type of provider (Family Practice, Internist, Dentist)**

Provided below are two sample charts of data collected for the period July 1, 2004 – October 31, 2004. As data from more CPHCs are uploaded and center staffs trained, comprehensive reports will be available to NJ DHSS for analyses and decision making purposes.

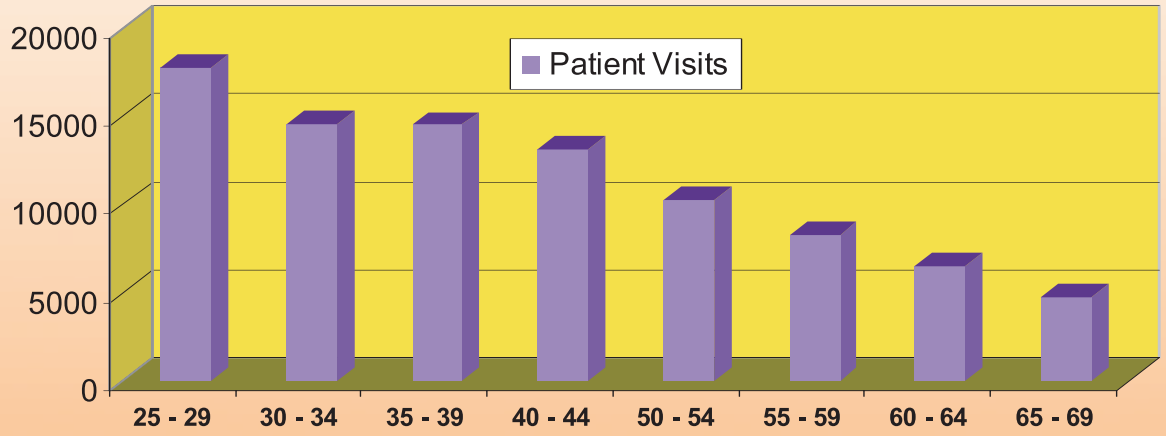
Sample data in Exhibit 1 will provide a summary of the number of visits made by diagnosis.

Exhibit 1
NJ Centers for Primary Health Care
Sample Summary of Patient Visits and Diagnosis



Data Collected in Sample Exhibit 2 will provides summary data on patient visits by age cohorts.

Exhibit 2
Sample NJ Centers for Primary Health Care (CPHC) Patient Visits by Age



V. Who receives health care services at New Jersey Centers for Primary Health Care?

In 2003, over 243,000 New Jersey residents sought needed medical, dental and mental health services at NJ CPHCs, generating over 800,000 patient visits. Over 1,325 physicians, nurse practitioners, psychiatrists, nurses, certified nurse midwives, dentists, dental hygienists, and other personnel comprised the care and support teams that served these patients. Of the patients using the centers, 61.2 were female and 38.8 percent were male. By the end of calendar year 2005, it is anticipated that patients will make over 1 million visits to existing CPHC facilities.

According to the New Jersey Primary Care Association, over 279,656 patients received primary health care services at NJ CPHCs as of December 31, 2004. This data will be verified by the U.S. Department of Health and Human Services/HRSA by the summer of 2005 and released for public consumption. The estimated insurance status of patients receiving services at New Jersey CPHCs during the 2004 calendar year is provided in **Table 4**.

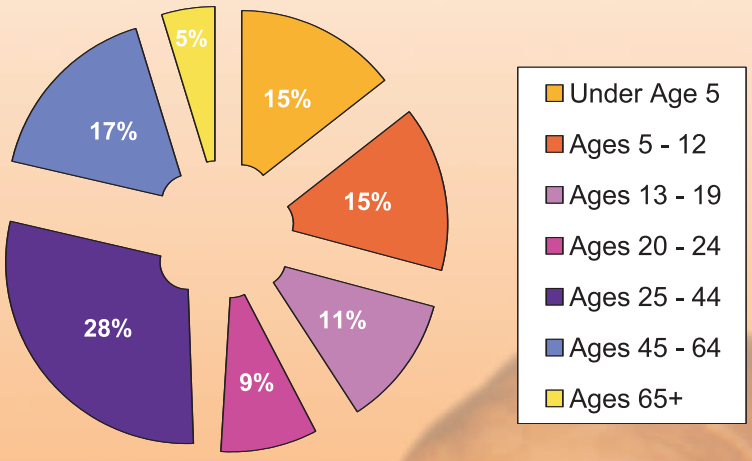
Table 4
Insurance Source of CPHC Patients
January – December, 2004*

Uninsured 129,555	(46.3%)
Medicaid/SCHIP 113,152	(40.5%)
Other Ins./Patient Fees	26,504 (09.5%)
Medicare	10,445 (03.7%)
Total Patients	**279,656 (100%)**

*Quick Facts, NJ Primary Care Association, 2005

As identified in **Exhibit 3**, 37 percent of the patients who seek care at NJ CPHCs are between the ages of 20 and 44. Children ages 0 to 5 represent 6.7 percent of New Jersey's population. Yet, this age group represents 15 percent of the patients who receive primary care at New Jersey's CPHCs.

Exhibit 3
New Jersey Health Center Patients by Age, 2003



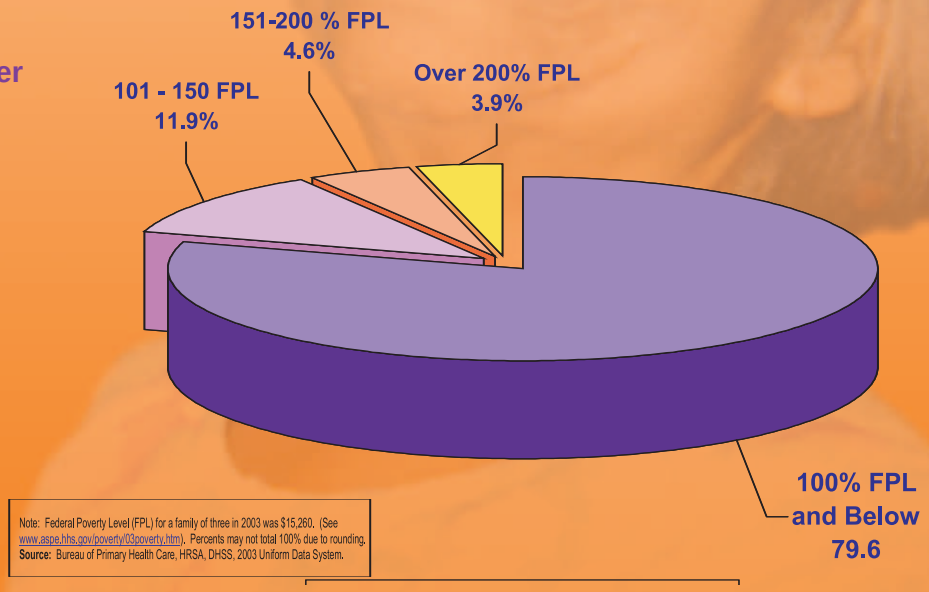
Source: Bureau of Primary Health Care, HRSA, DHSS, 2003 Uniform Data System

Patients by Income

As indicated in **Exhibit 4**, 79.6 percent of the patients who receive care at New Jersey CPHCs have incomes of 100 percent or less of the federal poverty level, compared to 8.5 percent of New Jersey residents with incomes 100 percent or below the federal poverty level.

Exhibit 4

New Jersey Health Center Patients by Age, 2003



Use of Federal Poverty Guidelines

Since household incomes, federal poverty guidelines and thresholds play a significant role in determining the eligibility of residents for most publicly funded programs, it may be appropriate to define the guidelines and the family income used to determine financial eligibility for various federal and state supported programs.

The guidelines are published each year in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs.[5]

The poverty guidelines are the other version of the federal poverty measure. In February of each year, the U.S. Department of Health and Human Services (DHHS) releases official income level for poverty according to family size. **Table 5** identifies Federal Poverty Level Guidelines for years 2000 through 2004. As indicated, a family income of $18,850 for a family of four equals 100 percent of the FPL guidelines.

According to the Kaiser Commission on Medicaid and the Uninsured, in 2003 over 8 in 10 uninsured people have workers in their families, 70 percent from families with one or more full-time workers, and 12 percent from families with part-time workers. Even at the lower income levels, the majority of the uninsured have workers in their family.

Table 5
Federal Poverty Level Guidelines
2000 – 2004

Year	First Person	Each Additional Person	Three-Person Family	Four-Person Family
2004	$ 9.310	$3,180	$15,670	$18,850
2003	8.980	3,140	15,260	18.400
2002	8.860	3,080	15,020	18,100
2001	8.590	3,020	14,630	17,650
2000	8,350	2,900	14,150	17,050

Primary Care Physician and Dentistry Loan Redemption Program of New Jersey

The State of New Jersey's Primary Care Physician and Dentist Loan Redemption Program (NJLRP) was created to alleviate the state's misdistribution of primary care physicians and dentists in rural and urban areas. The Loan Redemption Program (LRP) provides financial support toward outstanding educational debt of physicians and dentists who agree to work in medically underserved areas and health professions shortage areas, full time, for a minimum of two years.

Eligibility requirements include New Jersey residency, satisfactorily completion of an accredited residency in internal medicine, general pediatrics, family practice, and obstetrics and gynecology; licensed to practice in New Jersey, etc. Dentists must have completed an undergraduate dental training or primary care residency in general dentistry or pedodontics. Qualified educational loans are redeemed up to a maximum of $120,000 during a four (4) year period of service

During the period 1992 through December 31, 2004, NJLRP funding has been used to place 186 providers in 14 New Jersey counties designated as federal and/or state underserved areas. These providers generated 912,426 patient visits during their participation in the program.

Given the current enrollment in the program, NJLRP only has sufficient funds to enroll one (1) additional primary care provider, and has 23 approved providers awaiting placement at a projected cost of $2.1 million.

As the cost of medical/dental/graduate education continues to rise, debt is becoming a major concern for health care professionals. For the past 13 years, the NJLRP has assisted NJ Centers for Primary Health Care (CPHC), free standing facilities and private practice offices in recruiting and securing employment of primary health care providers in areas of need. Without the incentive offered by NJLRP, many providers may otherwise take advantage of more lucrative offers in private practice and/or more affluent communities. An increase of $1 million for the program would assure more placements in New Jersey, with priority being given to Governor Codey's initiative to expand CPHCs to more needy areas of the state.

[5] How the Census Bureau Measures Poverty, U.S. Census Bureau, August, 2004

Patients by Race

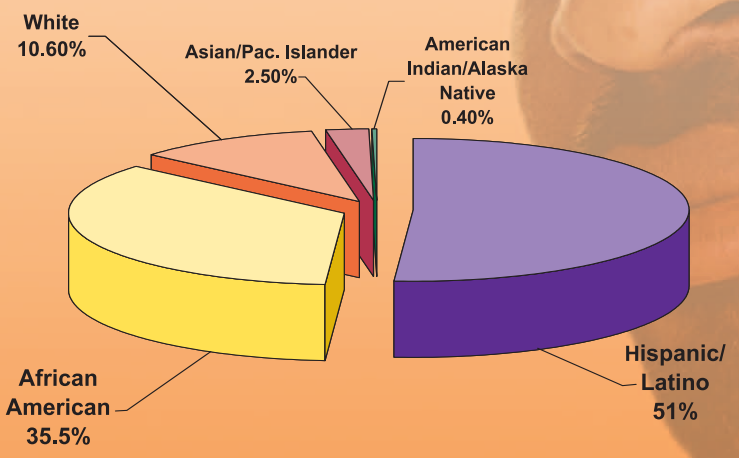
The U.S. Census Bureau recorded New Jersey's population at 8,414,350 persons in 2000. In 2004, the estimate increased to 8,618,879.

Hispanic/Latino persons accounted for 13.3 percent of the total. As identified in **Exhibit 5**, 48 percent of the patients presenting at NJ Centers for Primary Health Care register as Hispanic/Latino. The disproportionate percentage of Hispanic/Latinos patients at these centers can be attributed to undocumented citizens and migrant and seasonal farm workers who seek services at CPHCs.

African Americans comprise 13.6 of New Jersey's population, but 35.6 percent of the patient population at CPHCs. Other patients who receive care at CPHCs are white (10 percent), Asian/Pacific Islanders (1.9 %), and American Indian/Alaska Natives (0.4%). The race/ethnicity of six percent of the patients was not reported.

Exhibit 5

New Jersey Health Center Patients By Race/Ethnicity, 2003



Source: Bureau of Primary Health Care, HRSA, DHSS, 2003 Uniform Data System.

VI. Primary and Preventive Services and Programs

In caring for the medically underserved, CPHCs are required to provide a broad range of services. Assessments of the needs of individual communities, the identification of existing services, collaborations with other publicly funded programs and the availability of public transportation often determine the services offered. Although the number of women enrolled for services at CPHCs usually exceed those of men, the location of the center and/or needs in the community, race/ethnic differences and other factors may skew the population mix of children, senior citizens, annual births, etc.

Required Primary Health Services

Federal statute and regulations require that CPHCs provide a comprehensive array of services either directly, through contracts or cooperative agreements. ***Required services include:***

Pediatric/Well Child Care; Immunizations
Internal Medicine/Geriatric Services
Obstetrics/Prenatal and Perinatal Services
Gynecology/ Family Planning
Emergency and Preventive Dental Services
Diagnostic Laboratory and Radiology Services
Screening for
- ***Elevated Blood Lead Levels***
- ***Communicable Disease and Cholesterol***
- ***Hypertension***

Social Services/Case Management
Patient Education and Outreach
Patient Transportation
Interpretive Services
Medicaid Eligibility Services
Substance Abuse and Mental Health Services[6]

Federal guidelines also suggest that services beyond those required should be provided based on the needs and priorities of the community, the availability of other resources to meet those needs and the resources of the health center. Thus, some CPHCs may offer services that are missing in their immediate community, including:

Specialty Services

Podiatry/Foot Care
Ophthalmology/Vision Care
ENT (Ears, Nose and Throat)
Orthopedic Care
Genetic Counseling
Behavioral Health Services and Substance Abuse Counseling
Radiology
Other

[6]Programs receiving funding to serve homeless individuals and families also must provide substance abuse services. Substance abuse services include treatment for alcohol and/or drug abuse and may use a variety of treatment modalities such as: non-hospital and social detoxification, non-hospital residential treatment and case management and counseling support in the community. While these service requirements are specific to programs receiving funding for this special population, all health centers are encouraged to ensure access to these services for all their patients. Source: U. S. Department of Health and Human Services/HRSA, Health Center Program Expectations, April 17, 1998, Policy Information Notice 98-23.

After-Hour Coverage and Hospitalization

Federal regulations require that CPHCs provide comprehensive and continuous care that includes care during hours in which the health center is closed. Some CPHCs provide "urgent care" programs that extend far beyond the normal work day, thus allowing patients access to care in a primary care setting as opposed to a hospital emergency department.

At a minimum, CPHCs provide evening and Saturday operating hours and "call coverage" services. The latter typically entails use of an answering service when the center is closed. As patients seek assistance during off-hours, the answering service contacts the "on call" clinician who in turn calls the patient and recommends a course of action.

As a part of their operating procedures, all CPHCs must have ongoing referral arrangements with one or more hospitals. Health center providers are required to have admitting privileges and hospital staff membership at their referral hospital so that CPHCs patients can be followed by CPHC clinicians. Center clinicians should have firmly established arrangements for hospitalization, discharge planning and patient tracking.

Over one million patient visits will be made to NJ Centers for Primary Health Care in 2005

Pharmacy Discount Programs

Americans fill about 3 billion prescriptions each year. For millions, especially those without health insurance coverage, the decision to use limited resources for either living expenses or for lifesaving medications are made too often.

In 1992 Congress enacted Section 340B of the Public Health Service Act to address the large volume of prescription medications consumed by medically underserved patients utilizing federal programs. Section 340B requires that drug manufacturers provide outpatient drugs to eligible centers for primary care, clinics and hospitals (also known as "covered entities") at a reduced price.

The 340B price is a "ceiling price". It is the highest discounted price a covered entity would pay for selected outpatient and over-the-cover drugs and the minimum savings a manufacturer must provide. The 340B price is at least as low as the price that state Medicaid agencies currently pay.

Acting Governor Richard Codey meets new client at a recent opening of the Jersey City Family Health Center Pharmacy in Jersey City, NJ. The Acting Governor wants all eligible community health centers to participate in the 340-B Pharmacy Discount Programs.

Acting Governor Richard Codey Participates in Ribbon-Cutting Ceremony to Open New Pharmacy at Jersey City Family Health Center

Left to right: *Assemblyman Louis Manzo; Carol Ann Wilson, Director, Hudson County Dept. of Health and Human Services; Senator Joseph Doria; Jersey City Mayor Jeremiah Healy; Jonathan Metsch, President/CEO Liberty Health System; Acting Governor Richard Codey; Patrick Beaty, MD, Medical Director, JCFHC; Marlo Schuhalter, Owner/Pharmacist, Health Care Pharmacy; Assemblyman Vincent Prieto; and, Scott Carey, Administrative Director, JCFHC.*

The Pharmacy Affairs Branch of the U.S. Department of Health and Human Services/HRSA must be notified of the eligible program's intent to take advantage of the discounted prices. Once approved, participating health entities can determine the operating model that works best for its program. Models range from on-site, center operated pharmacies to contracts with local neighborhood pharmacies. Some agencies work with drug manufacturers directly or with wholesalers.

CPHCs and other participating entities have reported savings that range between 25-50% for covered outpatient drugs as a result of the low 340B prices. The 340B Drug Pricing Program improves healthcare delivery in participating communities by using cost savings to:

- **Reduce the price of medications for patients;**
- **Expand the number of drugs included in formularies;**
- **Increase the number of indigent patients served;**
- **Expand other services offered to patients by CPHCs.**

Five New Jersey Centers for Primary Care (CPHC) now participate in the 340B Drug Discount Pricing Program. They are North Hudson Community Action Corporation (Hudson County), AtlantiCare Health Services (Atlantic County), CAMCare Health Corporation (Camden County), Community Health Care (Cumberland County), and as of February 16, 2005, Jersey City Family Health Center (Hudson County).

Acting Governor Richard Codey recently proposed that all CPHCs participate in this program to increase access to needed medications for indigent and uninsured residents of the State and has offered assistance of the NJ Department of Health and Senior Services to:

- **Provide needed support to CPHCs and other NJ eligible providers to identity and study all 340- B Pharmacy Models and to assist them in determining which model works best for each community structure;**
- **Provide assistance in developing drug formularies;**
- **Assist in designing business plans;**
- **Assist in developing drug pricing schedules and sliding fee scales;**
- **Assist in structuring on-going drug utilization review activities; and**
- **Assist in identifying computerized claims and inventory replenishment systems.**

Chronic Disease Collaboratives

Federal initiatives over the past several years have encouraged Centers for Primary Health Care (CPHC) to develop and participate in health disparities collaboratives as a means of educating clinicians, nurses, other health care practitioners, health care administrators, patients and families on how to recognize and manage chronic diseases.

As CPHCs see more patients with costly chronic conditions such as diabetes, asthma, obesity and cardiovascular diseases, an approach to providing care to patients is one that focuses on a core set of prevention and chronic disease management measures. By promoting a greater teamwork approach among health professionals, by improving procedures to track treatments and reach out to patients and residents in the community, and by encouraging patients to take greater responsibility for monitoring their illnesses, collaboratives have proven to be effective in reducing the burden of illness due to harm done by chronic diseases.

The mission of the health disparities collaboratives is to achieve excellence in practice through the following goals that aim to:

(1) Generate and document improved health outcomes for underserved populations;
(2) Transform clinical practice through models of care, improvement and learning;
(3) Develop infrastructure, expertise and multi-disciplinary leadership to support and drive improved health status; and,
(4) Build strategic partnerships.

A population-based care model requires knowing which patients have an illness or need preventive service, assures delivery of evidence-based care, and actively helps patients and families to participate in their own care.

Most CPHCs in New Jersey participate in at lease one collaborative. Most notably are the CPHCs that participate in collaboratives that focus on diabetes and asthma – two chronic diseases with high prevalence rates in New Jersey.

Public/Private Partnership Results in Mammography Imaging and Ultrasound Equipment for Centers for Primary Health Care

In response to a challenge to the health insurance industry to invest in New Jersey communities and reach out to underserved populations from New Jersey's Department of Banking and Insurance, United Health Care and Oxford Health Plans (United's regional operation) purchased seven mammography systems and two ultrasound units for six NJ Centers for Primary Health Care in Atlantic, Camden, Essex, Hudson and Warren counties.

The $1.2 million charitable donation of the equipment, purchased from GE Healthcare, will make breast cancer screening available to over 15,000 women who utilize the following six recipient health care centers:

- East Orange Primary Care Center
- Newark Community Health Center
- CAMCare Health Corporation
- Jersey City Family Health Center
- Northwest New Jersey Community Action Program
- Southern Jersey Family Medical Center

New Jersey Cancer Education and Early Detection Programs

The New Jersey Cancer Education and Early Detection Program (NJCEED) is able to provide breast and cervical cancer outreach, education, screening and diagnostic procedures for breast and cervical cancers for low income (<250% of federal poverty level) uninsured and underinsured women. With federal funding targeted for women between the ages of 50 and 64, this program provides both screening and diagnostic services, including:

- **Clinical breast examinations.**
- **Mammograms.**
- **Pap tests.**
- **Surgical consultation**
- **Testing for women whose screening outcome is abnormal**

The state funding supports the same services as required by the federal program for women under 50 years of age, and for persons seeking screening for colorectal and prostate cancer. Women and men over 50 years of age, who meet the eligibility criteria, are screened for colorectal cancer, and men over 50 years of age may be eligible for prostate cancer screenings. Black men 40 years of age or older who are at high risk for prostate cancer may be eligible for prostate cancer screenings.

In fiscal year 2005, New Jersey State support for the NJCEED Program was doubled from $2.7 million to $5.4 million. Added to the $3 million in federal support, $8.3 million is available for cancer screens of low-income and underinsured women and men in New Jersey. It is anticipated that 15,000 women will be screened for breast and cervical cancer and that more uninsured men and women will have better access to colorectal and prostate cancer screening tests.

Although the NJCEED services are available in all 21 counties in New Jersey, less than half of NJ Centers for Primary Health Care (CPHC) are actively involved in the program as NJCEED provider agencies or as participating agencies. Based on the high number of uninsured (46.3%) patients who receive services in NJ CPHCs, every center will be encouraged to become an active provider or participating agency in the NJCEED Program in SFY 2005 and SFY 2006.

HIV/AIDS Counseling and Testing Programs/Rapid HIV Testing

Approximately 30,000 people in New Jersey are living with HIV/AIDS, and according to the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services, between 10,000 – 15,000 New Jerseyans are HIV positive and do not know it. Many of those who tested positive for HIV/AIDS live in New Jersey cities that are the home of Centers for Primary Health Care. **Table 6** below provides a summary of the ratio of HIV/AIDS infections among African Americans in 10 New Jersey cities:

Table 6
Rate of HIV/AIDS Infections
Among African Americans in 10 New Jersey Cities, 2004

Atlantic City	One in every 31 African Americans
Newark	One in every 32 African Americans
Elizabeth	One in every 44 African Americans
Jersey City	One in every 48 African Americans
Paterson	One in every 49 African Americans
East Orange	One in every 56 African Americans
Trenton	One in every 62 African Americans
Irvington	One in every 63 African Americans
Plainfield	One in every 75 African Americans
City of Camden	One in every 97 African Americans

Since November 2003, NJDHSS has trained and licensed hospital emergency departments, community-based agencies and Centers for Primary Health Care to use the rapid HIV test to diagnose patients during routine visits. More than 10,600 people in New Jersey have taken the rapid HIV test and received their results within 20 to 40 minutes.

Four of NJ CPHCs are funded by the State of New Jersey or the federal Centers for Disease Control and Prevention as HIV/AIDS Counseling and Testing Sites. Others collaborate with other area counseling and testing sites in their communities to assure that their patients have access to HIV/AIDS services. In January, 2005, Newark Community Health Center participated in the roll-out of a marketing campaign focused on African American women. That campaign encouraged the target group to take control of their sexual lives by getting tested. The accompanying image is a sample of the graphics being used on billboards and printed materials statewide.

Health Care for the Homeless Programs

Since 1987, the U. S. Department of Health and Human Services/HRSA has provided support to community agencies, hospitals and other agencies for health care services specifically targeted to vulnerable individuals and families experiencing homelessness or at risk for homelessness.

The Stewart B. McKinney Homeless Assistance Act of 1987 recognized that people experiencing homelessness lacked access to health care and that the mainstream healthcare safety net system was not responding to these unmet needs.

Congress reauthorized the HealthCare for the Homeless Program (HCH) in 1996 via the Health Centers Consolidation Act. That law consolidated community health centers, migrant health centers, health centers for residents in public housing, and HCH projects under a single, five-year authorization, but retained each of the four programs as a distinct activity. The most recent reauthorization in 2002 via the Health Care Safety Net Amendments Act retained the relationship between HCH projects and other health centers.

There are five (5) federally funded HealthCare for the Homeless Programs in New Jersey:

- **Project H.O.P.E., Camden, NJ**
- **Atlanticare Health Services, Atlantic City, NJ**
- **Newark Homeless Healthcare Project, Newark, NJ**
- **Henry J. Austin HealthCare for the Homeless Program, Trenton, NJ**
- **Jersey City Family Health Center HealthCare for the Homeless Program, Jersey City, NJ**

HealthCare for the Homeless Programs emphasize a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

In SFY 2005 each HCH Program in NJ received a grant from the NJ Department of Health and Senior Services to enhance their delivery of care to homeless individuals and families, to support each agency's participation in statewide activities sponsored by the New Jersey Primary Care Association (NJPCA), and to develop the pathway for sharing patient utilization data collected by the data warehouse operated by KeyCare, Inc. (a subsidiary of NJPCA).

Nationally, there are nearly 500,000 HCH clients in 50 States, the District of Columbia and the Commonwealth of Puerto Rico. The majority of the clients (59 percent) are male, between the ages of 20 and 44. The populations served are some of our country's neediest Americans, including persons living on the street, in shelters, and in transitional housing. More than 85 percent of the clients have no financial resources. The majority of the clients (73 percent) have no public or private health insurance.[7]

[7] National Health Care for the Homeless Council, Because Health Care is a Right Not a Privilege, 2002.

Federal National Health Service Corps Loan Repayment Program

Approximately 50 million people live in over 3,000 communities in the U.S. that have been designated as Health Professions Shortage Areas (HPSA) because of the limited number or absence of medical professionals available to address the health care needs of medically underserved populations.

Individuals living in HPSAs have little or no access to primary health care services because the demand for services exceeds the available resources, the services are located a great distance away, or are otherwise inaccessible.

For over 30 years, the National Health Service Corps (NHSC) has provided services in inner cities, farm towns, mountain villages, and migrant communities. The NHSC recruits health professionals committed to serving underserved populations, -- wherever they are.

In return for their service and commitment, participant in the NHSC are eligible for assistance with medical school loans. The National Health Service Corps Loan Repayment Program identifies fully trained and licensed primary health care clinicians dedicated to meeting the health care needs of medically underserved communities. This Program makes contract awards to clinicians for service at community sites eligible under the National Health Service Corps in designated health professional shortage areas. In exchange for this service, National Health Service Corps Loan Repayment Program participants receive funds for the repayment of their qualifying educational loans that are still owed, plus tax assistance.

To be eligible for loan repayment, you must be fully-trained in one of the following disciplines:

- **Allopathic (MDs) or osteopathic (DOs) primary care physicians**
- **Primary care certified nurse practitioners (NPs)**
- **Certified nurse-midwives (NMs)**
- **Primary care physician assistants (PAs)**
- **General practice dentists (DDSs/DMDs)**
- **Registered clinical dental hygienists (DHs)**
- **Psychiatrists (MDs/DOs)**
- **Clinical or counseling psychologists (CPs)**
- **Clinical social workers (SWs)**
- **Psychiatric nurse specialists (PNSs)**
- **Marriage and family therapists (MFTs)**
- **Licensed professional counselors (LPCs)**

A number of New Jersey communities are designated has HPSAs, resulting in a number of medical and dental professionals being employed in health centers and hospitals that provide needed services to medically underserved populations. Communities that meet specified criteria demonstrating a shortage of medical and dental professionals may be eligible to recruit such professionals and offer opportunities for them to participate in the National Health Service Corps or the New Jersey Loan Redemption Programs.

A Tribute to Michael A. Leggiero (1947 - 2005)

For almost 35 years, Michael A. Leggiero and his team of managers and community activists built their own "great society" in over a dozen communities in North Hudson County, New Jersey.

The journey of the North Hudson Community Action Corporation began when the first seeds of hope were planted in 1965 with financial assistance from the newly established federal Office of Economic Opportunity. With this support, a small group of caring individuals, striving to improve the quality of life in Hudson County, created the North Hudson Community Action Corporation (NHCAC). Michael joined this tiny band of believers in 1971, in the heart of the movement of the 1960s and 1970s designed to empower communities to take responsibility for their health, education and welfare.

Fueled with passion, savvy and dedication, 34 years later, Michael Leggerio's efforts are reflected in an organization that boasts a budget of $37 million, 600 employees and 20 programs that serve 70,000 residents. His efforts were borne out of a belief that all individuals deserve comprehensive health and human services, delivered with pride and dignity, regardless of culture or economic status. NHCAC services include job placement, transitional housing, nutritional counseling and support, behavioral health and substance abuse treatment, senior treatment and education program and comprehensive primary health care.

Under Michael's leadership, NHCAC joined the community health center "movement" in 1977 and received financial support from the U.S. Department of Health and Human Services/HRSA to implement primary health care services. Now JCAHO accredited, the federally funded community health center operated by NHCAC is the largest center for primary health care in New Jersey, with health care sites in West New York, Union City, Jersey City, North Bergen, Hoboken, Passaic, and coming soon to a site in Garfield.

To the administrators, clinicians support staff and the thousands of clients and patients served by North Hudson Community Action Corporation, we offer our condolences and share your pride in the legacy of the organization built by Michael Leggiero, you and your committed Board of Directors. May you find peace in knowing that Michael did what he wanted to do . . . be a part of a movement to improve the quality of life in his community.

"Michael lives on through the thousands of lives he touched. Today we grieve, but tomorrow we serve" . . . – Excerpt from Michael Leggiero Eulogy, Congressman Robert Menendez

NJ Migrant & Seasonal Farm Workers Health Programs

Many farms and employers hire migrant or seasonal workers to harvest crops or other agricultural products. Farm workers are the poorest group of workers in the U.S. Agricultural employment is currently listed by the Department of Labor as having the highest rate of fatalities and injuries among workers in the U.S., followed by mining.

Estimates of the U.S. farm worker population vary, but we know that each year between three and five million people leave their homes to follow the crops. Agricultural labor requirements in a given area may vary greatly between the different phases of planting, cultivating, harvesting, and processing. Farm workers' labor is crucial to the production of a wide variety of crops in almost every state in the nation.

Who are these workers? The migrant population is a diverse one, and its composition varies from region to region. However, it is estimated that 85% of all migrant workers are minorities, of whom most are Hispanic (including Mexican- Americans as well as Mexicans, Puerto Ricans, Cubans, and workers from Central and South America). The migrant population also includes Black/African Americans, Jamaicans, Haitians, Laotians, Thais, and other racial and ethnic minorities. [8]

[8] National Center for Farmworker Health, Inc., Overview of America's Farm Worker, 2002.

Some workers must live apart from their families. They travel, work, and live in groups of single men, often under the supervision and control of a crew leader. Other workers, especially in the mid-western migrant stream, travel with their entire family. On average, farm workers earn less than $7,500/year per person for picking and packing the fruits and vegetables that we eat every day.

Most farm workers pay U.S. taxes, whether they have legal documentation to work in the U.S. or not. Some farm workers are in the United States temporarily; others live here permanently and may be U.S. citizens. For at least the past 70 years, farm workers in the United States have included recent immigrants looking for a better way of life for their families back home.

The Migrant Health Act was enacted in September 1962 and was subsequently added to Section 310 to the Public Health Service Act. The Health Resources and Services Administration (HRSA) provides grants to community nonprofit organizations for a broad array of culturally and linguistically competent medical and support services to migrant and seasonal farm workers (MSFW) and their families. Migrant Health Centers are currently authorized under the Health Centers Consolidated Care Act of 1996, section 330(g) of the Public Health Service Act.

According to a 2002 migrant demographic study[9], the estimated three to five million migratory and seasonal farm workers in the U.S. include approximately 30,000 individuals and families working on farms in the State of New Jersey.

The federal Migrant Health Program (MHP) currently provides grants to 125 public and nonprofit organizations that support the development and operation of 400 migrant clinic sites throughout the United States and Puerto Rico.

Two NJ CPHCs are funded by HRSA to provide primary health and support services for migrants and seasonal farm workers. Southern Jersey Family Medical Centers, Inc. located in Atlantic and Salem Counties and Community Health Care, Inc. in Cumberland County both offer comprehensive services to farm workers and their families.

Migrant health services may include primary care, preventive health care, transportation, outreach, dental care, pharmaceutical services, and environmental health education. These programs use lay outreach workers, bilingual, bicultural health personnel, and culturally appropriate protocols often developed by the Migrant Clinicians Network. They also provide prevention-oriented and pediatric care at Migrant Health Centers, such as immunizations, well baby care, and developmental screenings.

Mental Health Programs

In view of limited mental health services available to medically underserved populations nationally, the U.S. Department of Health and Human Services/HRSA began to provide limited funding to federally qualified CPHCs to establish on-site primary Mental Health/Substance Abuse (MH/SA) services.

Federal guidelines encouraged centers to either provide the services directly or by contract with the local mental health and/or substance abuse provider. A review of studies conducted by nationally recognized mental health professional organizations supported known theories that access to mental health and substance abuse services greatly contributed to improved patients' health outcomes.

[9] Alice Larson and Luis Plascenia, "Migrant Enumeration Study", Washington, D.C., 1993.

According to the National Institute of Mental Health, an estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year. When applied to the 1998 U.S. Census residential population estimate, this figure translates to 44.3 million people. In addition, 4 of the 10 leading causes of disability in the U.S. are mental disorders -- major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Many people suffer from more than one mental disorder at a given time.

Research conducted by the Institute of Medicine (1997) has shown that underlying mental health/substance abuse problems account for up to 70% of all primary care visits. Depression, in particular, is predicted to be the second leading cause of disability in the United States by 2020. Depression can occur as a primary MH/SA problem, as a co-morbid condition with other MH/SA problems (e.g., Attention Deficit Hyperactivity Disorder (ADHD), substance abuse) or as a co-morbid condition with other medical problems (e.g., chronic diseases, such as diabetes or arthritis). Although evidence-based treatments exist for depression, many individuals in need of services are never identified as having a problem, and fewer than half of those identified as needing treatment actually receive it (Institute of Medicine, 1997).

Today, eight CPHCs provide on-site MH/SA services. These services are provided either under contract with a community mental health agency licensed by the State of New Jersey, or directly by the professional staff of the centers in a licensed program. The level of MH/SA services range from state certified and accredited behavioral health programs to counseling and support offered by Licensed Clinical Social Workers. The resources available for behavioral health services at CPHCs are limited and non-crisis community MH/SA referrals are a major issue.

VII. CPHC Licensure, Accreditation, Provider Credentialing and Education

All CPHCs must be licensed by the NJ Department of Health and Senior Services in compliance with NJ Standards for Licensure of Ambulatory Care Facilities. Additionally, many CPHCs participated in accreditation activities and have participated in Joint Commission for the Accreditation of HealthCare Organization (JCAHO) surveys. As of January, 2004, six NJ Centers for Primary Health Care were JCAHO Accredited.

Provider Credentialing

All health centers are expected to maintain a core staff of primary care clinicians with training and experience appropriate to the culture and identified needs of the communities they serve. CPHCs define standards for assessing training, experience and competence of clinical staff in order to assure the clinicians ability to qualify for hospital privileges and payer credentialing.

Credentialing of CPHC clinical staff follows a formal process which includes querying the National Practitioner Data Bank and verifying education and licenses. Credentialing and privileging processes meet the standards of national accrediting agencies such as the JCAHO or other accrediting organizations. Additionally, clinicians must meet the requirements for coverage under the Federal Tort Claims Act (FTCA).

The participation of federally funded CPHCs in FTCA coverage for medical malpractice claims is an incentive for many centers when recruiting medical professionals. However, specific credentialing and privileging requirements must be met.

1. **Credentialing is the process of assessing and confirming the qualifications (e.g., licensure, certification, and/or registration) of a licensed or certified health care practitioner; and**

2. **Privileging is the process of authorizing the specific scope and content of patient care services of a licensed or certified health care practitioner. This is performed in conjunction with an evaluation of the health care practitioner's clinical qualifications and/or performance.**

The CPHC can satisfy many of the credentialing and privileging requirements by utilizing primary source verification for providers. Primary source verification is verification of an individual health care practitioner's reported qualification by the original source or an approved agent.

Examples of approaches to primary source verification of credentials include direct correspondence, telephone verification, or internet verification from the original qualification source or reports from credentials verification organizations (CVOs). For example, the Education Commission for Foreign Medical Graduates (ECFMG), the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) Physician Database, or the American Medical Association (AMA) Masterfile can be used for primary source verification of health care practitioners' education and training. Hospitals also can serve as CVOs to conduct primary source verification for CPHCs.

Continuing Medical Education

All CPHCs are required to provide for continuing medical education for clinicians, a critical element to the provision of quality of care. In an effort to decrease health care disparities and to increase access to care, many CPHCs maintain affiliations with clinical training programs that contribute to the objectives of health professionals in training.

VIII. Health Center Governance

One of the key elements to the continuation of CPHCs over for 40 years has been the federal requirement that the centers must be run by a board of directors. Federal guidelines dictate that at least 51 percent of the members of the board be consumers of the center's services. Many policy makers believe that this requirement has been a centerpiece to the success of the community health center movement. Board members who are consumers of the center's service are able to participate in policy discussions based on their own experiences in using the services, and their interaction with support staff and clinicians.

Governance by and for the people served is an essential and distinguishing element of the health center program. CPHCs must have a governing body that assumes full authority and oversight responsibility for the health center. The governing board must maintain an acceptable size, composition and meeting schedule.

CPHCs receiving federal support, designated as a Look-Alike, or providers planning to apply for federal grant support must document that their governing boards are composed of individuals who represent the population being served by the organization. Additionally, the majority of the members of the Board of Directors must be consumers of the services of the center. This requirement has been the cornerstone of the success of federally funded community health programs for 40 years.

Health Center Locations and Sites

County	Name	Street Address	Main Site	Site Status *
Atlantic	AtlantiCare Health Services HCH	2009 Bacharach Blvd., Atlantic City 08401	X	Operational
Atlantic	AtlantiCare Health Services	2500 English Creek Avenue, Egg Harbor Twp. 08234 - (609) 344-5714		Admin only
Atlantic	South Jersey Family Medical Center	860 So. White Horse Pike, Hammonton 08037 - (609) 567-0200	X	Operational
Atlantic	South Jersey Family Medical Center Dental Center	310 Bellevue Avenue, Hammonton 08037		Operational
Atlantic	South Jersey Family Medical Center at Pleasantville	932 South Main Street, Pleasantville 08232		Operational
Atlantic	South Jersey Family Medical Center at Atlantic City	1301 Atlantic Avenue, Atlantic City 08041		Operational
Atlantic	Wilbur "Huff" Royal Community Health	1401 Atlantic Avenue, Atlantic City 08401 - (609) 441-1377	X	Operational
Atlantic		1325 Baltic Avenue, Atlantic City 08401		Under Development
Bergen	North Hudson Community Action Corp Health Center	535 Midland Avenue, Garfield 07026 - (201) 866-9320		Under Development
Burlington	South Jersey Family Medical Center at Lisbon	600 Pemberton-Browns Mills Road, Pemberton 08068 - (609) 567-0200		Operational
Camden	CAMcare Health Corp	817 Federal Street, Suite 300, Camden 08105 - (856) 541-3270	X	Operational
Camden		2610 Federal Street, Camden 08105		Operational
Camden		Sixth & Erie Streets, Camden 08102		Operational
Camden		Eighth & Carl Miller Blvd, Camden 08103		Operational
Camden		3100 Federal Street, Camden 08105 (Woodrow Wilson High School)		Outreach
Camden		Baird & Park Blvds., Camden 08103 (Camden High School)		Outreach
Camden	Our Lady of Lourdes Project H.O.P.E.	1600 Haddon Avenue, Camden 08103 - (856) 635-2475		Admin. Only
Camden		439 Clinton Street, Camden 08103	X	Operational
Cumberland	Community Health Care, Inc.	105 Manheim Avenue, Bridgeton 08302		Operational
Cumberland		251W. Broad Street, Bridgeton 08302 (Broad High School) Teen Center		Contract
Cumberland		111 N. West Avenue, Bridgeton 08302 (Bridgeton Street School)		Contract
Cumberland		Route 553, Newport, NJ 08345 (Kids' Corner - Downe Elementary School)		Outreach
Cumberland		P.O. Box 5115, Seabrook 08302 (Cumberland Regional High School)		Outreach
Cumberland		70 Cohansey Street, Bridgeton 08302 - (856) 451-4700	X	Operational
Cumberland		319 Landis Avenue, Vineland 08302		Operational
Cumberland	Millville Community Health Center	1200 North High Street, Millville 08332		Operational
Essex	Newark Community Health Centers, Inc.	741 Broadway, Newark 07104 - (973) 483-1300	X	Operational
Essex		751 Broadway, Newark 07104		Operational
Essex		444 William Street, East Orange 07017		Operational
Essex		101 Ludlow Street, Newark 07114		Operational
Essex		516 Bergen Street, Newark 07102		Operational
Essex		832 Chancellor Avenue, Irvington 07111		Operational
Essex		982 Broad Street, Newark 07102		Operational
Essex	Newark Homeless Health Care Project	394 University Avenue, Newark 07102 - (973) 733-5300	X	Operational
Hudson	Horizon Health Center	714 Bergen Avenue, Jersey City 07306 - (201) 451-6300	X	Operational
Hudson		418 Summit Avenue, Jersey City 07306		Operational
Hudson		316 Communipaw Avenue, Jersey City 07304		Outreach
Hudson		239 Bergen Avenue, Jersey City 07305 (Snyder High School)		Outreach
Hudson	Jersey City Family Health Center	935 Garfield Avenue, Jersey City 07304 - (201) 946-6460	X	Operational
Hudson		953-961 Garfield Avenue, Jersey City 07304		Operational
Hudson		115 Christopher Columbus Circle, Jersey City 07302		Operational
Hudson		5300 Bergenline Avenue, West New York 07093		Operational

* As of April, 2005

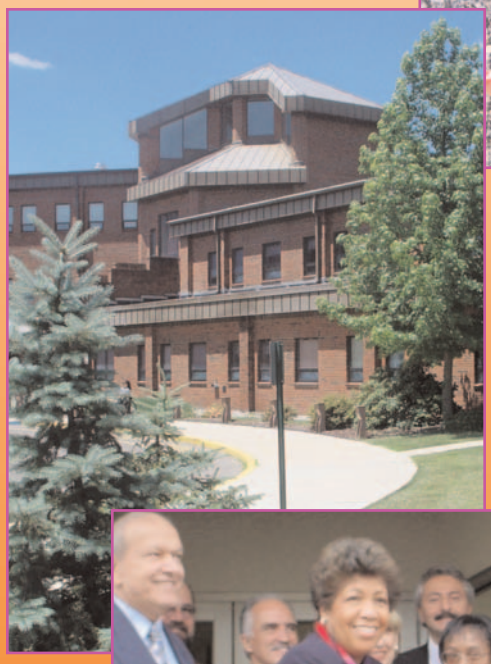
Year Opened and Licensed	FQHC Status	Federally Funded (Year)	Year Funded for Capacity Building & New Access Points		Type of Site					
			Federal	State	Primary Health Only	Primary Health & Dental	Dental Only	School Based	Homeless	Migrant
2003	FQHC 330H	2003	2003	DHSS - Addiction Services 04, DHSS - Office of Primary Care 05					X	
1977	FQHC 330E and G	1978		DHSS - Office of Primary Care 04	X					X
1997							X			X
1996	Satellite				X					X
2002	Satellite			DHSS - Office of Primary Care 04		X				
1992	FQHC-LAL 2002				X	X				
				DHSS- Office of Primary Care 04		X	X			
				DHSS- Office of Primary Care 04	X	anticipate dental if funding available				
2005	Satellite	2004		DHSS- Office of Primary Care 04		anticipate dental if funding available				
2004	FQHC 330E	1978	2003			X				
1995	Satellite			DHSS - Office of Primary Care 04		X				
1993	Satellite					X				
1983	Satellite					X				
1997								X		
1997								X		
1999	FQHC 330H	2002	2001	DHSS - Office of Primary Care 05					X	
2004	Satellite			DHSS - Office of Primary Care 04		X				X
1991-licensed	Satellite							X		
1988 - licensed	Satellite							X		
1991								X		
2000								X		
2003	FQHC - 330E and G	1978			X					X
1987	Satellite		2001			X				
2004	Satellite				X					
1986	FQHC 330E	1986				X				
2000	Satellite				X					
1994	Satellite				X					
1986	Satellite				X					
1986	Satellite				X					
2004	Satellite			DHSS- Office of Primary Care 04		X				
2004	Satellite			DHSS - Office of Primary Care 04	X					
2000	FQHC 330H	2001	2004-05	DHSS - Office of Primary Care 05					X	
1978	FQHC 330E	1999		DHSS - Office of Primary Care 04		X				
2001	Satellite		2001			X				
2000										
2000								X		
1988	FQHC 330E & H	1988			X					
1987	FQHC 330H								X	
1995	Satellite			DHSS - Office of Primary Care 04		X				
1993	Satellite				X					

County	Name	Street Address	Main Site	Site Status *	Year Opened and Licensed
Hudson	Jersey City Family Health Center (cont.)	140 Martin Luther King Drive, Jersey City 07305		Outreach	
Hudson	North Hudson Community Action Corp. Health Center	5301 Broadway, West New York 07093 - (201) 866-9320	X	Operational	1994
Hudson		5301 Broadway, West New York 07093 (mobile only)		Operational	1994
Hudson		324 Palisade Avenue, Jersey City 07307		Operational	1999
Hudson		1116 43rd Street, North Bergen 07047		Operational	1999
Hudson		714 31st Street, Union City 07087		Operational	1999
Hudson		124 Grand Street, Hoboken 07030		Operational	2005
Mercer	Henry J. Austin Health Center	321 N. Warren Street, Trenton 08618 - (609) 989-3599	X	Operational	1976
Mercer	Chambers Manor	317 Chambers Street, Trenton 08609		Operational	1988
Mercer	Ewing Health Center	72 Ewing Street, Trenton 08609		Operational	1993
Middlesex	Eric B. Chandler Health Center	227 George Street, New Brunswick 08901 - (732) 235-9099	X	Operational	1988
Middlesex		123 Church Street, New Brunswick 08901		Under Development	
Middlesex		George Street, New Brunswick 08901 (New Brunswick High School)		Outreach	1991
Middlesex	Jewish Renaissance Medical Center	272A Hobart Street, Perth Amboy 08861 - (732) 293-0135	X	Operational	2001
Middlesex		351 Mechanic Street, Perth Amboy 08861 (St. Mary's Pre-School)		Under Development	
Middlesex		300 Eagle Avenue, Perth Amboy 08861 (Perth Amboy High School)		Under Development	
Middlesex		415 Fayette Street, Perth Amboy 08891 (Elderly Care)		Under Development	
Middlesex		271 State Street, Perth Amboy 08861 (McGuiness School)		Under Development	
Middlesex		380 Hall Avenue, Perth Amboy 08861 (Shull School)		Under Development	
Monmouth	VNA of Central Jersey	572 Cookman Avenue, Asbury Park 07712 - (732) 219-7480	X	Operational	1994
Monmouth		35 Broad Street, Keyport 07735		Operational	2002
Monmouth		1003 Sunset Avenue, Asbury Park 07712 (Asbury Park High School)		Outreach	
Monmouth		1200 Bangs Avenue, Asbury Park 07712 (Asbury Park Middle School)		Outreach	
Monmouth		1300 Bangs Avenue, Asbury Park 07712 (Asbury Park Bank Ave. Elem. School)		Outreach	
Monmouth	Monmouth Family Health Center	270 Broadway, Long Branch 07740 - (732) 923-7146	X	Operational	2004
Monmouth		300 Second Avenue, Long Branch 07740		Operational	2004
Morris	Dover Community Clinic	17 South Warren Street, Dover 07801	X	Operational	1994
Ocean	Ocean Health Initiatives, Inc.	101 Second Street, Lakewood 08701 - (732) 363-6655	X	Operational	2004
Passaic	North Hudson Community Action Corp Health Center	110 Main Avenue, Passaic 07055 - (201) 866-9320		Operational	2004
Passaic	Paterson Community Health Center	32 Clinton Street, Paterson 07522 - (973) 278-2600	X	Operational	1976
Passaic		227 Broadway, Paterson 07522		Operational	1995
Salem	South Jersey Family Medical Center	238 East Broadway, Salem 08079 - (609) 567-0200		Operational	1994
Sussex	NORWESCAP	238 Spring Street, Newton 07860 - (908) 454-7000	X	Operational	2005
Union	Plainfield Health Center	1700-58 Myrtle Avenue, Plainfield 07063 - (908) 753-6401	X	Operational	1969
Union		155 First Street, Elizabeth 07206		Operational	2002
Union		950 Park Avenue, Plainfield 07060 (Plainfield High School - Cardinal Health Center)		Contract	1996 licensed
Union		427 Darrow Avenue, Plainfield 07060 (The Healthy Place - Washington Elementary School)		Contract	2000 licensed
Union		1200 Myrtle Avenue, Plainfield 07063 (Jefferson Elementary School)		Outreach	
Union		Clinton Avenue & W. 4th Streets, Plainfield 07060 (Clinton Elementary School)		Outreach	
Union		201 W. 4th. Street, Plainfield 07060 (Stillman Elementary School)		Outreach	
Warren	NORWESCAP	350 Marshall Street, Phillipsburg 08865 - (908) 454-7000		Admin only	
Warren		422 South Main Street, Phillipsburg 08865	X	Under Development	

* As of April, 2005

FQHC Status	Federally Funded (Year)	Year Funded for Capacity Building & New Access Points		Type of Site					
		Federal	State	Primary Health Only	Primary Health & Dental	Dental Only	School Based	Homeless	Migrant
FQHC 330 E	1997	2003	DHSS - Office of Primary Care 04		X				
Satellite				X					
Satellite					X				
Satellite				X					
Satellite					X				
	2004		DHSS - Office of Primary Care 04		X				
FQHC 330E&H	1986	2002-03	DHSS - Office of Primary Care 04		X			X	
Satellite			DHSS - Office of Primary Care 04	X					
Satellite									
FQHC 330E	1991	2002			X				
		2005	DHSS - Office of Primary Care 04		X				
							X		
FQHC 330E	2002			X					
							X		
							X		
				X					
							X		
							X		
FQHC 330E	2003		DHSS - Office of Primary Care 04	X					
FQHC-LAL 2002			DHSS - Office of Primary Care 04	X					
							X		
							X		
							X		
FQHC- LAL 2004			DHSS - Office of Primary Care 04	X					
Satellite			DHSS - Office of Primary Care 04		X				
FQHC 330E	2004		DHSS - Office of Primary Care 04		X				
FQHC 330E 2005	2005	2005	DHSS - Office of Primary Care 04		X				
FQHC 330E	2004		DHSS - Office of Primary Care 04		X				
FQHC 330E	1979		DHSS - Office of Primary Care 04	X					
Satellite	1995				X				
Satellite					X				x
Satellite			DHSS - Office of Primary Care 04			X			
FQHC 330E	1977	2001-02	DHSS - Office of Primary Care 04		X				
Satellite					X				
Satellite							X		
Satellite							X		
							X		
							X		
							X		
			DHSS - Office of Primary Care 04						
				X					

New Centers and Programs...



New Beginnings...

Centers for Primary Health Care • Caring for the Medically Underserved

"A Promise Made . . . A Promise Kept"

1965 – 2005

Celebrating 40 Years of America's Commitment to Primary Health Care*

- **1965: 100,000 Patients Served**
  First "Neighborhood Health Centers" funded under demonstration authority by federal Office of Economic Opportunity (OEO), the lead agency in the "War on Poverty" effort of the Johnson Administration. Centers are funded in Boston, MA; Mound Bayou, MS; and Denver, CO.

- **1970: 500,000 Patients Served**
  National Association of "Neighborhood Health Centers" (later to become National Association of Community Health Centers) is founded by executives of OEO-funded "Neighborhood Health Centers", to provide education, training and technical assistance to health center staff and Community Board Members.

- **1975 – 1977: 1 Million Patients Served**
  "Community Health Centers" program authorized for the first time as a permanent program (after 10 years as a demonstration effort, first under OEO and later under the US Department of Health, Education and Welfare); Migrant Health Program reauthorized (Public Law 94-63), but only after Congressional override of President Ford's veto. President Jimmy Carter subsequently calls for major expansion of health centers, including the "Rural Health Initiative", more than doubling program funding over four years.

- **1980 – 1981: 5 Million Patients Served**
  The Reagan Administration's "New Federalism" proposes shifts and block grants numerous federal programs to the states, including block granting Community and Migrant Health Centers. The National Association of Community Health Centers led massive efforts to exempt health centers – resulting in optional block grant taken by only one state, and allowing health centers to survive the greatest threat in their brief history.

- **1985 – 1987: 5.5 Million Patients Served**
  Health centers rally sufficient bipartisan support to repeal optional block grants and return programs to direct federal-local partnership basis; State and Regional Primary Care Associations (S/RPCAs), formed by health centers to monitor state policy developments, received first federal funding and recognition; Health Care for the Homeless program established through the Stewart McKinney Homeless Act.

- **1989 – 1992: 6 Million Patients Served**
  President George H. Bush proposes health center expansion, increasing federal funding more than $150 million. Congress centralizes health centers' grants administration, establishes Federally Qualified Health Centers (FQHCs) in both Medicaid and Medicare (making services a guaranteed benefit and requiring cost-based payments), and extends malpractice coverage under Federal Tort Claims Act (FTCA) to health centers as only non-governmental covered entities. Congress creates new program (340B) requiring pharmaceutical manufacturers to sell medicines to health centers and other safety net providers at deeply discounted rates.

- **1995 – 1997: 9 Million Patients Served**
  Despite strong Congressional efforts to block grants or dismantle numerous health programs (including Medicaid), health centers secure 5-year reauthorization of Community, Migrant and Homeless Health Center programs as consolidated authority and help to defeat Medicaid block grants. Congress and White House subsequently agree to major changes in Medicaid that accelerated the use of managed care systems, including "wrap-around" payments that eliminate health center losses under Medicaid managed care, but also call for phase-out of Medicaid FQHC payment system and the creation of new Children's Health Insurance Program (CHIP).

- **2000: 12 Million Patients Served**
  Congressional health center supporters stave off phase-out of Medicaid FQHC payments, replaced it with a Prospective Payment System (PPS) that avoids huge revenue losses; and, introduce REACH Initiative to double health center funding over 5 years. Both Presidential candidates embrace plan to double health centers and more than 60 percent of Congress supports first step. Health centers federal funding surpasses $1 billion.

- **2001 – 2002: 13 Million Patients Served**
  President George W. Bush fulfills campaign pledge by calling for 5-year initiative to increase health centers funding by $700 million. Congress unanimously passes Health Centers reauthorization law, boosts federal funding by $175 million in first year, adding to President Bush's request (+$124 million).

- **2002 – 2004: 15 Million Patients Served**
  Health centers overcome major obstacles to secure 4-year reauthorization of consolidated Health Centers authority (Section 330), including new authority to provide operational support to health center-owned/operated networks. Also reauthorized for 4 years is National Health Service Corps program authorities, including automatic Health Professional Shortage Area (HPSA) designation for all FQHC sites and new requirements that all NHSC sites must agree to an "open door" policy and use of sliding fee system. Congress enacts new Medicare "wrap-around" payment system (similar to Medicaid), and establishment of special Fraud and Abuse "safe harbor" for donated/discounted services, goods and supplies from vendors or other providers Congress adds to Bush funding requests for health centers, reaching $1.6 billion for FY 2004 (60 percent above FY 2000 level), while state funding – despite fiscal crisis gripping most states—approaches $350 million.

* Source: "A Promise Made, A Promise Kept", Community Health Center Forum, January/February, 2005, National Association of Community Health Centers, Inc, Issue 6, Number 1, 2005, National Association of Community Health Centers, Inc, Issue 6, Number 1.

Richard J. Codey
Acting Governor

Fred M. Jacobs, M.D., J.D.
Commissioner